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ABSTRACT

The Memphis (Tennessee) City Schools Program for Autistic Children offers a comprehensive program which includes a day school and a residential training center with emphasis on language training. The primary objective of the day school is establishing and maintaining behavioral control through opearant conditioning techniques. Other aspects of the day school include socialization and academic training at three levels: the lowest level with children whose academic and behavioral skills are most deficient; the middle level, made up of children whose most disruptive behaviors are under control; and the highest level, with students whose next step should be inclusion into the educational mainstream. The residential training center provides service in four major areas: full service care (3-6 months of training in the full complement of skill areas offered); hot spot care (service in fewer than five skill areas, most frequently in dressing and eating); respite care (up to 2 weeks of behavior control to give relief to parents); and crisis intervention (provided when there is a chaotic home situation). The language training program aims toward language normalization through individual language therapy, language activities in the classroom, and education of the parents in home instruction. (SB)

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A COMPREHENSIVE PROGRAM FOR AUTISTIC CHILDREN:

Services provided by the

Memphis City Schools

Memphis, Tennessee

by

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Presented At

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A COMPREHENSIVE PROGRAM FOR AUTISTIC CHILDREN

HISTORY AND ADMINISTRATION

The children served by the Memphis City Schools Program for Autistic Children are recognized as those with the most severe communication and behavior disorders. Typically, they are diagnosed as psychotic, aphasic, autistic, as well as those with multiple labels such as severely retarded with autistic characteristics. They are the children who until a few years ago spent their lives in either fruitless, bizarre, and self-stimulatory behavior or completely withdrawn from all human contact—even to the point of refusing to eat or be touched. Some overtly destroyed themselves by banging their heads or severely damaging their own eyes. These are the children who disturbed, unnerved and frightened us in strange and unspeakable ways. These are the children who were being excluded from any public education program. Even now, in some systems, they are systematically being excluded from any service. We feel strongly that all children, no matter how severe their disability, have the right to become all they are capable of becoming, that it is morally untenable, legally unjustifiable, and financially unsound to exclude these or any children from public education.

The word education is used in its broadest and most pragmatic terms. We teach a child what he needs to learn. Often these needs are not traditionally thought of as within the realm of public school teaching; but surely we have all learned that serving the exceptional child means we must often disregard traditional thinking, traditional methods, and traditional skills.

We are truly concerned with the whole child. The program feels there is no skill, no subject, no deficit in learning we will defer from teaching. We must be concerned with all areas of development if we are to follow our model of normalization. What do we mean by normalization? To train and teach each child to look and act as would a regular child of his own age. For some of our children that is an almost impossible task, but we must have a standard by which to measure the children and the standard of normalcy is the only logical measure to use. We are always striving for our children to become all they are capable of becoming. We always assume a child is able to perform a task until he unequivocally and irrevocably proves to us he cannot. This is not blind optimism on our part; rather it's the basis for a thinking set about the children. It's a frame of mind; a method of looking at children that focuses on the positive aspects of the children—what they are <u>able</u> to do rather than what they are <u>unable</u> to do. We feel this thinking set is of the utmost importance because our children are so very often seen only as "a bundle of problems" and nothing more. When all adults are cuing into positive aspects of the child, we're able to paint the child in a positive light and everyone who deals with him learns to expect the appropriate from him. We think this is critical since the problems and deficits of the children usually jump out at the adults. Our program allows us to touch every area of the child's life, if that is necessary. How have we been able to accomplish this and why would we want to are two of the most frequently asked questions about our program.

In 1971, the Memphis City Schools opened a day program for our children. The program was in direct response to the pleas of a number of parents. Located

in an elementary school, the teachers and other children were first apprehensive about us, our children, and our teaching techniques. But they soon saw the great need the program was fulfilling and we, too, made a great effort to be accepted and to help them understand. For as I'm sure you realize, the program needed the support of everyone from the principal to the custodial staff in order for it to truly succeed. The program uses teaching techniques based on principles of operant conditioning almost exclusively. Operant conditioning techniques combined with common sense, adult enthusiasm, warmth, and a sequential step by step, highly structured breakdown for every task to be taught provide the backbone for the program. Each year since 1971, a new teacher has been added and the day program has been grouped into developmental levels of beginning, middle, and higher functioning children. In 1975, the Board of Education was again able to meet the particular needs of our children by opening a short term residential facility. At this point we were able to provide for almost every possible need a child may have from the most elementary, such as toileting skills, up through high level academic skills. The day school program is primarily concerned with teaching those skills needed to function adequately in a school setting. The residential facility is concerned with teaching those skills that parents normally teach children at home. Since the children's major disabilities are language and behavior, both day and residential programs deal heavily in this area. The program utilizes a team approach to working with the children. Everyone who has any contact with a child must utilize the same teaching methods and techniques. Our children cannot learn without the consistency of a team approach. Teachers meet bi-weekly on a formal team meeting. They also remain in contact by phone on an informal basis.

The entire program is administered through the Memphis City Schools Board of Education, Division of Special Education. The day program is funded almost exclusively through State and Local funds; the residential program is funded through a combination of Title III Federal and State and local money. The program receives support services from myriad agencies both within the Board of Education and outside the Board.

We are committed and feel we have both a moral and legal obligation to prepare our severely disabled children to live as normal a life as possible.

THE DAY SCHOOL PROGRAM

The day school accepts as its role in our comprehensive program that of teaching the children to survive in an educational environment. At the lower functioning levels this day school is almost clinical in appearance. Here the children attend classes for one half day sessions and are capable of only one to one working relationships. As more appropriate behaviors are learned and the child advances through the program to the highest level, the classrooms take on the look of a more "regular" special education class. The students attend for a full academic day and much of the time is spent in group situations working with and alongside their classmates.

The day school has developed some specific objectives. Of primary importance to all else we do is the establishing and maintaining behavioral control. Almost all children served have severe behavioral problems. Many of the students have been excluded from otherwise more appropriate placements and were sent to us for just this reason. Developing techniques to alleviate these behavioral abnormalities allows the child to begin functioning nearer his potential. Our staff is trained in the use of operant conditioning techniques such as pinpointing the target behavior, obtaining baseline information on this behavior, writing behavioral change programs, the use of reinforcement principles in implementing these programs, recording of data, and the evaluation of the objectives written for each child. The use of these skills combined with a low student-teacher ratio enables us to extinguish many behavioral excesses and to teach the children more appropriate actions. Of necessity, we place special emphasis on reducing tantrums, teaching the children to sit, to look at the teacher, to attend and follow directions.

Language training, another of our major objectives, occurs in all contexts of the student's experiences in school. This aspect of our program will be discussed later by our language therapist.

Hand in hand with behavioral control and language training goes the development of socialization and interaction skills. The autistic child must learn that others are significant and can be meaningful to him. He also needs to know that he has something to contribute to others. Language without this social interaction becomes only a tool with which the children entertain themselves. This characteristic is all too common with <u>verbal</u> autistic children.

In our socialization training, the children are taught to attend, to listen, to converse with others. First the teaching is with the teacher, then other adults, and soon with students who have already developed these skills.

This training is extended beyond the classroom into situations that are less structured—the cafeteria, the playground, the school bus, for trips into the comunity for shopping and lunch.

Self help skills such that are necessary to allow the child to function in a school setting are also part of our "curriculum." This includes teaching such things as toileting, dressing skills, eating skills, tooth brushing and other similar activities.

The day school is also responsible for the academic training of the students in this program. This teaching of traditional school skills, such as reading and mathematics is a major part of our role. The children function within a

wide range of academic abilities, from Lois, whose reading comprehension skills are at the eighth grade level, to Walter, who finds it difficult to work a four piece puzzle. The majority of the students can do academic work from the beginning kindergarten level to the end of the second grade.

The structure within which this school operates revolves around the three classrooms and the three levels they represent. The lowest level contains the children whose academic and behavioral skills are the most deficient. The teacher and the child must work together on a one to one basis. Behavioral management and language skills are stressed at this level. The child is introduced to small group settings but works directly with the teacher. They simply are not yet capable of more. Academic training usually is in the form of pre-readiness skill development.

The middle level class contains those children whose most disruptive behaviors are under control. Increased attention is placed on becoming more independent with the academic training. A larger percentage of the student's time is spent in small group work with much more interaction with their classmates.

The highest level classroom operates with those youngsters whose language, behavioral, and socialization skills as well as academic abilities are well advanced over the other two levels. The class is run rather like a small self contained special education class. Individual programming and teaching still exists, yet the students are capable of handling primarily group instruction. A considerable portion of their academic work is independently completed.

A natural upward extension of this highest level class is the turning of these students to the educational mainstream. We have been able to accomplish this to some extent with one half of the children this program has served in the five years of its existence:

Four children have been placed in kindergarten or in first grade in regular programs.

Six children were placed in resource programs.

Five in self contained learning disabilities classes.

Four children have made the transition to TMR classes.

Two of our former students are now in deaf or hard of hearing classes.

A unique aspect of the services offered the autistic children in Memphis has been the involvement of community agencies with our children. Diagnostic evaluations and consultative services have been extended to this program by the University of Tennessee Child Development Center and the Memphis State University Speech and Hearing Center.

Memphis State also offers us its facilities for summer school and we serve them as a training site for their masters and undergraduate teacher training programs in special education.

The University of Tennessee Dental College has cooperated closely with our teachers to train the children to permit dental examinations and restorative work.

The local YMCA has allowed us the use of its pool for swimming instruction. The American Red Cross assists by providing lifeguards and consultation on the techniques of this teaching.

The Community Relations Division of the Memphis Police Department has provided us transportation into our community that has permitted numerous training sessions.

The Memphis Society for Autistic Children has assisted us in ways that are simply too numerous to mention.

The day school, as can be seen, is traditional in its objectives about teaching children, but quite advanced in its approach to achieving these goals.

THE RESIDENTIAL TRAINING CENTER

The Residential Training Center offers service in four major areas.

1. Full Service Care. The child is scheduled to remain for three to six months. His training includes the full complement of skill areas offered.
2. Hot Spot Care. The child receives service in fewer than five skill areas. The most frequently requested are dressing and eating, but we've also worked on cooking or vocational skills with older children. This is the most flexible category since the child can attend as a day student or simply come a few hours a day.
3. Respite Care. In this category we take children up to two weeks as a relief for parents. Behavior control is exercised so he doesn't provide an inappropriate model for other children.
4. Crisis Intervention. We take children in this category when an incident in the home precipitates a drastic change in behavior or the child's behavior changes drastically for no apparent reason or even if home life becomes so difficult that the added burden of the handicapped child might throw an already chaotic situation into an unbearable disaster.

The Residential Center is open from Sunday through Friday; parents provide transportation to and from the Center. At present we have no means of providing weekend care.

We have a limit of six children. We arrived at that figure knowing the number of professional and para-professionals we had to work with. We have found, however, that six is the maximum that can be served and still maintain our prescriptive-type programs for each child.

Children are referred to the Center from many sources. An assessment team consisting of teachers, supervisors and parents decides if our program meets the needs of the child. Once the child is settled in, we do a thorough evaluation in all areas we're concerned with. This is a criterion referenced, systematic look at the child. The individual skills are listed hierarchically according to difficulty. The child is given three opportunities to perform each task in order to obtain the operant level of his skills. He is assessed using the following codes:

An A response is truly an operant level. The child performs the task appropriately without being instructed. After eating breakfast he brushes his teeth on his own.

B responses indicate that the child can perform the task but needs to be reminded to do so.

If a child attempts the task but apparently doesn't know how to do it, for instance he picks up the toothbrush but just holds it in his mouth, he receives a score of C.

D responses indicate that he behaved in some inappropriate manner—tantrumed, squeezed all of the paste from the tube, or threw the brush at the teacher.

If he does not respond at all, he receives a score of E.

To remove inconsistency and opinion from the assessment, behavioral objectives accompany each step required of a correct response. Occasionally a child may perform a task appropriately although not exactly as stated in the behavioral objective. This requires a "judgment call" by the professional in charge.

All tasks in which a child demonstrates proficiency (A or B responses) are placed on a "John can do" list and are posted. These are maintained. We then pick up several new skills from each skill area and begin training. Programs are written to teach each skill, insuring consistency and a high success rate for the child.

Every child is assessed and trained in the following skill areas: The self-help skills area includes eating, toileting, dressing, undressing, hygiene and grooming. There are over 100 skills taught in this area, from holding a spoon to choosing clothes appropriately. Assuming responsibility is an area of training we feel is unique. It includes skills that a normal child learns and does as a member of a family—such as making his bed, feeding the pet, setting the table, and putting his toys away.

Play and Socialization is divided into solitary play (things a child does alone), action games I (propelling an object at a target), action games II (riding a bicycle, swinging. playing in a sandbox, croquet), table games (from Candyland to Crazy 8's), and pretend toys (dollhouses, cars and trucks). We occasionally hear remarks of "You're teaching kids to play, and expect to be funded?!" Yes, that's exactly what we are doing and think it's a pretty good idea. If we are to follow our lead of normalization, then each child must learn adequate use of leisure time and to interact with others even if on a contrived and programmed

level. Each child is encouraged to go beyond this but if he is unable to, he at least has an appropriate model to rely on.

Our In-Community Program is also unusual. At least twice a week we take the children to various places in Memphis to learn skills appropriate for children of their age. We utilize parks, shopping centers, the grocery store, movies, quick food places, restaurants, department stores, specialty shops, pet shops, the post office, the airport, and the library as training areas. The children are taught such skills as how to walk through a store without touching things, to purchase items, to sit quietly, to order food, to mail letters, to use public restrooms and to interact as members of the community. Safety on streets and in parking lots is an integral part of the In-Community Program. The children are first taught to stop on command and finally to walk alone stopping at every curb and looking before stepping into a street.

Language programs are developed for each child with the guidance of our speech and language specialist and carried on throughout the day. Specific behavior control programs are also written for each child in addition to his other training. We feel that although there are certain behaviors to be eliminated, the child must <u>always</u> be taught an appropriate behavior to replace the old one. An example would be eliminating "Bad hands", that is, grabbing children and objects and teaching "Good hands", that is, keeping one's hands to oneself (at first, folded). New behavior is taught and maintained through the use of positive reinforcement. Punishment is used only when a specific behavior is so inappropriate that it either is dangerous to the child or prohibits the learning of skills necessary to his well-being.

The parent training program is critical to our services. It really doesn't matter what we can do with the children. If the parents cannot maintain it and teach new behavior, then where are we going? Our parents are involved weekly in three ways: In the Center, in the home, and as participants in a practical course in behavior modification. The in-center part of our program involves a 30-60 minute conference with staff to review their child's progress and discuss future training and a 2-4 hour training and observation period with their child. A professional staff member goes to each home once a week for in-home training and observation. This portion we have found is the critical ingredient needed for parents to gain success. A course covering the basic principles and practical applications involved in behavioral training is taught once a week at night by one of our teachers. All parents are asked to attend. Our parents are also involved in the In-Community Program. We have found that sharing the task of training appropriate grocery store behavior has eased the pressure felt by mothers who previously had braved it alone amid stares from other shoppers.

The Residential program then, while only in its infancy is contributing to meeting the needs of our children.

LANGUAGE TRAINING

Very generally, it is speech that provides the form and language that provides the content of our expression. Speech is an overt activity. It involves the production of sounds (like /p/) that are dependent on a system of communication—that being language.

Most speech training in the public schools deals with children who have been identified as functionally defective in their production of sounds. The deficiencies are usually best described as omissions (for instance, "pant" instead of "plant"), distortions ("shoe" instead of "shoe"), or substitutions ("wabbit" instead of "rabbit"). The children are usually normal, both physically and mentally. In our day school and in the Residential Center we are dealing with children who are not normal, who have not developed language in the same fashion that you and I have. They have a variety of disturbances which includes complete absence of speech, echolalic speech, singsong patterns, reversals of word order, pronoun reversals, delayed echolalia, extreme literalness and affirmation by repetition. Many of the children who come to this program have language deficiencies that are so pervasive, so total that, even at the level of knowing that there is a relationship between an object and the word that represents it, it is clear that a breakdown has already occurred. Some of our children speak, but their speech may be linguistically inappropriate to the situation. They <u>are</u> talking, but they are not <u>communicating</u>.

Here are some examples of the kinds of language that we run up against every day in school. First thing every morning we say hello to the children. It's not at all unusual when we say "Hello Ellen" and Ellen responds with "Hello

Ellen". This is a good example of echolalia; the child is spitting back exactly what we've just said to her. What we have to do in a situation like this is to make sure that Ellen does not have the opportunity to echo back what we've said. The most effective way of doing this is to take advantage of the problem—we say "Hello Ellen, Hello Blanche", giving her the appropriate response before she goes wrong, knowing very well from experience that Ellen is going to pick up on those last two words and respond appropriately with "Hello Blanche".

At any time during the school day we may be faced with indicating displeasure at a child's performance or lack of performance. One of the most popular phrases that we use for this purpose is, "I am not pleased, Donald". We get phone calls from parents in the evening asking, "When did Donald start saying, 'I'm not pleased', when he does something wrong." Obviously, the child did something that made mother unhappy and used the same words that we used in school in a situation very much like the one that he faced at home that evening. This is an example of delayed echolalia.

Pronoun reversals—we hear so much of this that we really have to be on our toes in terms of catching it and providing the child with an appropriate model. When Gary says "You want to go home" as his bus is waiting outside at 1:00 and he's looking at it through the window, we have a pretty good idea that <u>he</u> wants to go home, even though he didn't refer to himself by using "I".

A very, very important thing to mention in terms of success in language training is the age of the child when we first see him. There has been much research and a great deal of it supports the notion that if a child develops some degree of communicative speech during the pre-school period (or around the

age of 5), the prognosis for succeeding in all areas of development increases significantly. For this reason, we feel that we're clearly obligated to do all that we can in helping these children develop functional speech and language as early as possible.

The methods used in our program toward this goal are based mainly on two considerations—one, a review of the research that exists on behavioral and psychological disabilities typical of language impaired children and two, a decision regarding the techniques that have been proven to work toward accomplishing the goals that we define for each child. The procedures need to be systematic, carefully controlled, and efficient and they're always sequential in nature. We start at developmental Level I; when we establish success, we move on to developmental Level II, and keep going until we have the data indicating that that particular goal has been reached.

The teachers in our program all use these techniques in controlling the children's behaviors when they first come to us. We modify behavior to the point where a language evaluation can be given. At this time, as much of the child's language as possible is recorded, including which responses are appropriate and which are not, in what kind of circumstances they are appropriate and in what kind of circumstances they are not, which reinforcers are effective and which are not. The data may be based on observation in a free play situation if that seems most appropriate for the child. If, however, the child has shown some degree of verbal competence, we may set up a situation where language is required. As the child responds we have the opportunity to try out different forms of praise and reinforcement. In addition to observation, some of the

children are capable of a valid performance on a standardized language test. Instructions may have to be altered slightly, i.e. pointing instead of circling or head nodding instead of a yes or no verbal response. The Peabody Picture Vocabulary Test and the Boehm Test of Basic Concepts are two that the children respond well to and that we use often.

When therapy begins (speech, language, or both) the most important thing that we can do is to show the children success and try to relate this success to speech or language behavior. The behavior might be receptive in nature and not have any speech involved at all on the child's part. If he can't say "nose" but can point to it on command, then that is the task that we'll ask him to perform first. Upon completion of the task, we reinforce the child with whatever seemed to be rewarding during the initial evaluation. It may work, it may not. If it doesn't work, then we have to find something that does. This something may change from day to day. One day verbal praise may do it, the next day the child may need an edible reinforcer to get him going. Something that we've found extremely effective at this level (where success is a sure thing for the child) is the repetition of whatever it is that the child has done successfully. If the child just handed the roll call to the secretary, then we might say "Good job, Eddie. You gave the roll call to Mrs. Powell". We try to really bombard the kids with appropriate language at every opportunity.

Once the child is responding to us and to our methods of reinforcement, we go up another step in the language training program and present a task that is new to him. This is the true test of the effectiveness of teaching. If it's

a good one, and if, for instance, it's imitation of a behavior that we want, then imitation is what we should get (assuming, of course, that the child is capable of performing the task). From this point on, language therapy is simply a matter of following the steps outlined in the language program designed for the child. One of the programs that we use most often is the Monterey Language Program. It teaches syntactic structures starting with the most basic program for non-verbal children and working up, step by step, through plurals, negation, possession, etc., etc. We like both the thoroughness of the program and the strict reinforcement schedule designed for each step.

Another thing that we really like is to see how well the children carry over the language work that's done in the structured therapy setting to the classroom. Of course, we feel a responsibility to help them bridge this gap and it's a big one. But, normalization is our goal and realistically we're not in any way reaching for that goal if our children's language is limited to a small speech room.

Well, on to classroom activities. Communication is constant between the teachers at both the high school and the residential center and the language therapist. Most of the exchange takes place immediately after a child's individual language session. It's at this time that we work on that all-important carry over. We talk about carry over at the individual level and we also suggest possibilities for carry over in group work, perhaps at some later date.

At any time during the day the language therapist might be in the classroom and see the children taking part in a classroom language activity that could be done more effectively. If this happens, instead of individual therapy, the teacher and therapist try to modify that activity.

Beyond individual language therapy and language activities in the classroom, there is still one more step toward language normalization: the children's parents. Using their skills at school is fine, but again if the child goes home and is silent or inappropriate, what have we accomplished? In terms of language there are a number of different approaches used with parents. The Monterey Language Program has its own built in Home Carry-Over Program. If it's not a formal language program that we're dealing with, the parents often come in to observe their child in the classroom. Articulation work is usually observed in the speech therapy room where a mirror is available. After the parents observe, we do some observation of our own by asking them to duplicate, as best they can, the same kind of work that we just did with their child. We talk to the parents about situations they might set up in their own homes that would be suitable and beneficial to the child. And then ... the show is theirs.